



## Open Call to Local Health Departments: Expansion of the I-NEDSS Pilot

The Indiana National Electronic Disease Surveillance System (I-NEDSS) Project Team is expanding the I-NEDSS pilot. An open call was issued on September 12 with the goal of adding four-nine local health departments (LHD) to the existing pilot group (Hamilton, Hendricks, Johnson, Putnam, Floyd, and Kosciusko Counties). The pilot participants will review and provide feedback on the I-NEDSS application as a tool for processing and reporting communicable disease investigations. The pilot is anticipated to start on November 3 and run through the end of 2008. More information on the pilot expansion and the application process can be found in the I-NEDSS Pilot Plan, which is posted on the LHD Resource Web site at <https://myshare.in.gov/isdh/lhdresource/default.aspx>. The deadline for application to the I-NEDSS Pilot is October 10.

I-NEDSS is a Web-based application that promotes the collection, integration, and sharing of data at federal, state, and local levels. The purpose of I-NEDSS is to automate the current process for reportable diseases. The system will include lab reports, communicable disease reports (CDR), and case investigations. Eventually, I-NEDSS will replace the paper-based reporting and case investigation system currently in use. Benefits of I-NEDSS include increased speed, accuracy, and accountability with reportable disease surveillance, since all reporting and investigation forms are accessed, completed, and submitted electronically.

The Notification Module, released in I-NEDSS v2, focuses on the communication of lab reports and CDRs to the appropriate investigative unit at the local or state level. The role of moving communications among the various entities, including reference labs, hospital infection preventionists (IP), LHDs, field epidemiologists, and the subject matter epidemiologists, was piloted for functionality and accuracy.

The Case Investigation Module, released in I-NEDSS v3, focuses on the completion and electronic submission of a case investigation. Additional enhancements are planned that will

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allow LHDs to perform historical and quality assurance report queries. The Indiana State Department of Health (ISDH) will report case investigations to the Centers for Disease Control and Prevention (CDC) in a similar manner as they are reported currently.

The pilot project is being expanded to help ensure that I-NEDSS meets the needs of the LHDs and to allow for feedback from additional LHDs who will join the I-NEDSS Project Team in evaluating I-NEDSS.

The I-NEDSS Project Team will be responsible for selecting LHDs to participate in the expanded pilot. Selection criteria are listed below in priority order:

1) ***Commitment from the LHDs:*** The I-NEDSS Project Team is looking to measure commitment of the LHD in executing the goals of the pilot. To meet these goals, commitments must be secured from the Local Health Officer and administrative staff, as well as from the front-line nursing staff who will be performing the investigations. The I-NEDSS Project Team is testing a deployment model for disease surveillance that focuses on local commitment and buy-in as it relates to hospitals, physicians, and LHDs, with the LHD taking the lead in securing commitments from organizations that report disease surveillance data directly to the LHD. The I-NEDSS Project Team is looking for a high level of commitment from the LHD to make this project a success.

2) ***Source of Data:*** As mentioned above, the source(s) of data provided to I-NEDSS is important. CDRs are a key factor in initiating an investigation, and for a majority of the LHDs, it will be the only method for gathering electronic data. Laboratory data are currently available at the state level, but coverage areas beyond the Indiana Network for Patient Care ([www.inpc.org](http://www.inpc.org)) remain spotty at best. The more partnerships a LHD is able to form with hospital IPs and local health care providers who will submit the CDRs, the better the chances will be for success.

3) ***Availability for Training:*** Training for the LHDs participating in the expanded pilot will be conducted in person during a two-week period in late October. LHDs that can commit to training of key personnel during this time period will be favored. LHDs that can organize training in conjunction with local hospital personnel will be given priority.

4) ***Number of Investigations:*** The ability to demonstrate a high average number of investigations per month will be weighted as a priority. This criterion is a lower priority, but it would be beneficial for the LHDs to have a steady stream of investigations for which they can utilize the I-NEDSS application. A greater volume of investigations would enhance the LHDs' ability to evaluate and improve I-NEDSS.

5) ***Geographic Location:*** LHDs that share a border with any of the existing pilot counties, Hamilton, Hendricks, Johnson, Putnam, Floyd, and Kosciusko, will be favored in this category.

Selections will be made based on the above criteria; however, rankings will not be published. All LHDs that apply should expect to learn the status of their application by mid-October 2008. Counties that are not selected for the expanded pilot will be eligible for the first round of statewide rollout in 2009.

If you cannot access the I-NEDSS Pilot Plan posted on the LHD Resource Web site, please contact the I-NEDSS Project Team directly at [I-NEDSS@isdh.in.gov](mailto:I-NEDSS@isdh.in.gov).



# Easy Epidemiology for Everyone

*E<sup>3</sup> is a new feature of the Indiana Epidemiology Newsletter dedicated to exploring the fundamentals of epidemiology. Each month, a different epidemiology concept will be explored to enhance understanding of basic epidemiology.*

## Confidence Intervals

Tracy Powell, MPH  
ISDH Field Epidemiologist, District 4

As epidemiologists, we use the odds ratio (or risk ratio) to assess the statistical relationship between two or more variables, e.g., assessing the risk of a particular outcome if a certain exposure is present. But, how do we know if the odds ratio is significant to our investigation?

We calculate a confidence interval!

The confidence interval is a range of values on either side of the odds ratio or point estimate. It allows us to look beyond the dichotomy of “significant” and “not significant” and instead focus on a range of likely values. Ideally, the point estimate will be somewhere in the middle of the confidence interval.

The confidence interval consists of three components: the upper bound number, the lower bound number, and the confidence level. In public health, most confidence intervals have a confidence level of 95 percent, but other levels are commonly used, e.g., 90 percent, 99 percent. With a 95 percent confidence interval, if we repeated the investigation and used the same procedure each time (data gathering instruments, etc.), we would expect to see a point estimate in our interval range 95 percent of the time. This means we have a 5 percent chance of error or a 5 percent chance that the true value is not contained within the confidence interval. Most public health professionals are comfortable with this level of error.

The width of the confidence interval, i.e., the difference between the upper and lower bound numbers, signifies data precision. A narrow confidence interval suggests greater precision and usually results from having more data points (which usually means a larger sample size). Another factor that affects the interval width is the level of confidence. Looking at the same set of data, a 95 percent confidence interval is wider than a 90 percent confidence interval, and a 99 percent confidence interval is wider than a 95 percent confidence interval. Thus, the higher the confidence level, the wider the interval. The example below shows the different intervals with varying confidence levels.

## Confidence Interval Example

As you can see from the example, the widths of the confidence intervals are large even with the 90 percent confidence level. The wider confidence interval suggests lower precision and is probably due to a small sample size.

Odds Ratio	Confidence Level	Confidence Interval	Confidence Width
23.3	90%	6.29–84.72	±78.43
	95%	4.92–108.98	±104.06
	99%	3.01–2,972	±2,968.99

To bring the idea of the confidence interval all together, we will look at foodborne illness in Indiana residents who shopped at Store A compared to those who did not shop at Store A. The odds ratio or point estimate was 47.5, and the 95 percent confidence interval for the estimate was 10.08–224.36. We can say that the risk of illness in people who shopped at Store A (exposed) was 47.5 times the risk than in those who did not shop at Store A (unexposed). The confidence interval gives us an idea of how precise the odds ratio is and can also indicate statistical significance. A confidence interval that includes one is not statistically significant.

If you recall from a previous newsletter article on odds ratios, an odds ratio greater than one indicates a greater risk among those exposed, and an odds ratio of one means no difference between those exposed and unexposed. The lower bound number of the confidence interval was 10.08, which is greater than one. Thus, we can conclude that people who shopped at Store A were more likely to become ill with foodborne illness than those who did not shop at Store A.

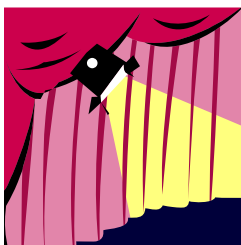
When results of an investigation are reported, including the confidence interval along with the p-value and odds ratio is necessary in order for the reader to appropriately comprehend the data and draw relevant conclusions.

Odds Ratio	95% Confidence Interval	p-value
47.5	10.8–224.36	<0.005

Understanding statistical methods is an overwhelming task that can take years and many daunting statistics courses. However, over the past several months we have presented the odds ratio, risk ratio, p-value, and confidence interval, which are a few statistical methods that can be easily applied to most public health investigations. Understanding these basic concepts will assist you in reporting and understanding investigation findings.

## References

1. Kuzma, Jan. Basic Statistics for the Health Sciences. 3<sup>rd</sup> Edition. 1998.
2. Leonard Braitman. Confidence Intervals Assess Both Clinical and Statistical Significance, *Annals of Internal Medicine*, 1991; Vol. 114, pp 515-517.



## **OUTBREAK SPOTLIGHT....**

*Outbreak Spotlight is a regularly occurring feature in the Indiana Epidemiology Newsletter to illustrate the importance of various aspects of an outbreak investigation.*

### **OUTBREAK OF GASTROENTERITIS ILLNESS AT A FEDERAL CORRECTION COMPLEX**

Rob Allen, MPA  
*ISDH Field Epidemiologist, District 7*

Karen Scully, RN  
*Infection Control Coordinator, Federal Correction Complex*

#### ***Background***

On March 28, 2008, Dr. Thomas Webster, Clinical Director with the Federal Correction Complex (FCC), notified the Indiana State Department of Health (ISDH) of an outbreak of gastroenteritis occurring at the FCC in Terre Haute, Indiana. Approximately 35 prisoners had developed diarrhea and vomiting at the Federal Correctional Institute unit, one of three buildings that houses inmates at the FCC facility. At that time, the complex had approximately 3,200 prisoner population and 750 employees. The ISDH contacted the Vigo County Health Department (VCHD) to confirm that a gastrointestinal outbreak was occurring and to recommend infection control measures.

#### ***Epidemiologic Investigation***

The VCHD and the ISDH initiated a collaborative investigation of the outbreak. A case was defined as any previously healthy person who was incarcerated or worked at the FCC and became ill with diarrhea and/or vomiting from March 27 to April 9. The ISDH developed a questionnaire which documented illness history and food and water consumption. FCC representatives interviewed inmates and staff, and it was determined from onset dates that the outbreak was not likely related to the facility's food services. No food workers were reported ill prior to or during the outbreak, and the epidemiologic evidence pointed to a viral infection being transmitted from person to person. None of the employees reported ill household members.

Two data sets were collected during the investigation: a cumulative case count (N=124) and questionnaires (N=55). The two data sets were found to have discrepancies in the onset dates and likely contained duplicative cases. Due to federal confidentiality procedures, identifiers were not able to be provided during the outbreak. The investigative team determined that the cumulative count had the most accurate reference for onset dates, as these were collected directly by FCC

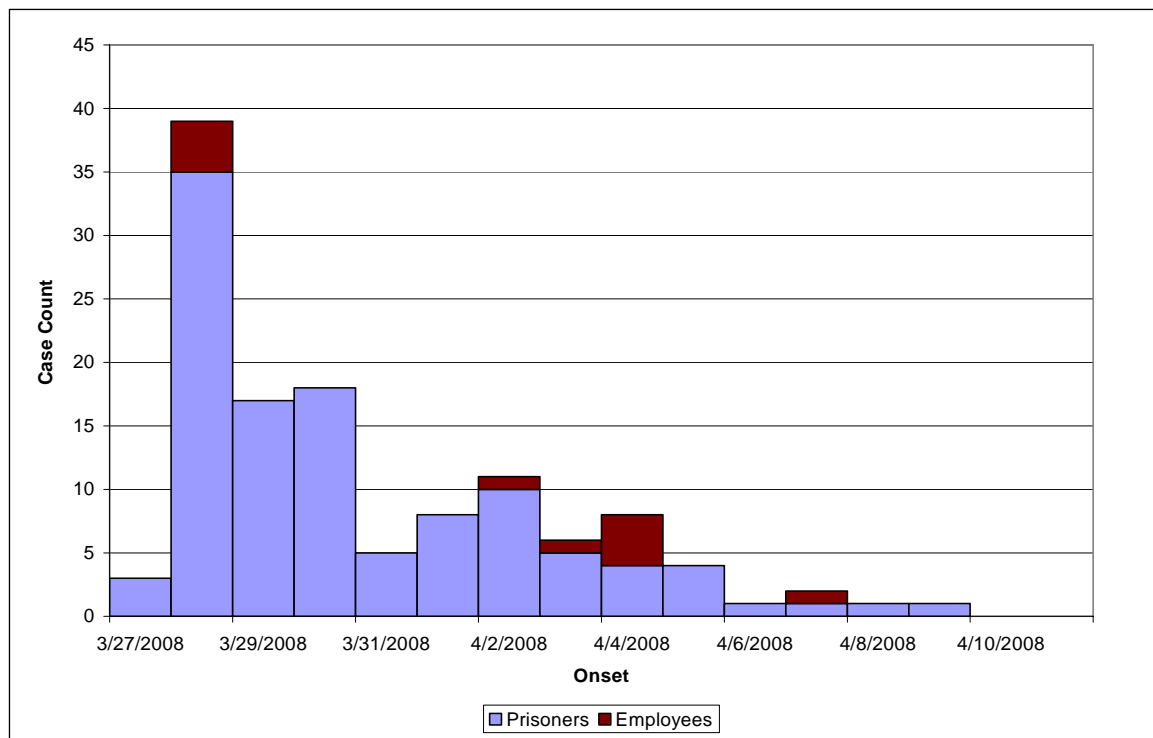
officials during the outbreak. However, the questionnaires provided more detail on symptoms. Both sets collected data that would satisfy the established case definition.

The FCC interviewed 55 inmates using the ISDH questionnaire. Predominant symptoms included: diarrhea (98%), vomiting (87%), and nausea (80%). The mean duration of illness was 45.60 hours. The median incubation period could not be calculated due to the uncertainty of the start of the incubation period.

Once it was determined that the outbreak was not foodborne and the agent was confirmed *Norovirus* (see Laboratory Results), interviews were no longer conducted. The FCC collected onset and symptom data on an additional 69 inmates and staff; in total, 124 persons met the case definition (see Figure 1). The attack rate was 3.5 percent for the entire FCC prison population.

Inmates are housed in three buildings, each of which has its own cafeteria that provides food services. The majority of the ill inmates were housed in the Federal Correction Institute (FCI) unit. The FCI unit housed approximately 1,500 prisoners, 250 staff members, and had 103 reported cases. Only 21 cases were housed in the Federal Prison Camp (CAMP) and the United States Penitentiary (USP) units. However, many staff members and inmates travel among all three units. The FCC was also a major hub within the Federal Bureau of Prisons; over 6,000 inmates travel in and out of the facility within a year.

**Figure 1: Epidemiologic Curve (N=124)**



### ***Environmental Assessment***

Thorough hand washing using soap and thorough cleaning and disinfection procedures using a 10 percent chlorine solution were implemented throughout the three unit facilities. Lockdown procedures were implemented in the FCI and CAMP units to contain the outbreak. Also, the

Federal Bureau of Prison officials stopped transporting inmates until the outbreak was over. Inmates who were ill or became ill were isolated from other inmates, and staff members were excluded from the facility until symptoms ceased. Staff members were instructed to implement hand-washing procedures when entering another unit, and measures were implemented to limit staff movement between units. The FCC alerted visitors regarding symptoms associated with gastroenteritis and precautionary measures that should be implemented to prevent the spread of the disease.

### ***Laboratory Results***

Six stool specimens were submitted to the ISDH Laboratory for analysis. Five of the six specimens tested positive for *Norovirus*. Once the specimens tested positive for *Norovirus*, specimens were not tested for bacterial agents, based on the symptoms and rapid resolution of illness. Foods were not collected because epidemiologic evidence did not support a foodborne vehicle of transmission.

### ***Conclusions***

This investigation confirms an outbreak of gastroenteritis occurred at the Federal Correction Complex-Terre Haute between March 27 and April 9, 2008. During this time, approximately 113 prisoners and 11 staff members became ill with vomiting and diarrhea. The only common exposure among cases during the weeks of March 27 and April 9 was attendance at the FCC facility. No cases of gastroenteritis were reported outside of the facility.

The causative agent of this outbreak was *Norovirus*. Five cases tested positive for *Norovirus*, and clinical symptoms were compatible with noroviral illness. Evidence indicates that the illness was transmitted person to person rather than through a point source, such as food. Although the sharp increase in cases on March 28 and the gradual decline of subsequent cases shortly thereafter suggests a point-source transmission according to the epidemic curve (Figure 1), no common meal was identified, and no food workers were reported as ill. Person-to-person outbreaks can have patterns similar to point-source outbreaks if many people are exposed within a short amount of time. The subsequent peaks in the curve indicate secondary transmission.

Agents of viral gastroenteritis are passed in the stool or vomitus, and people generally become infected by ingesting stool from a person (fecal-oral route). The virus is easily spread by contaminated food or beverages, from person to person, and by contact with a contaminated object. These viruses can remain infectious on surfaces for up to 72 hours, and only a very small amount of virus is needed to cause infection. Symptoms include watery diarrhea, vomiting, cramps, nausea, headache, and fatigue. Symptoms usually begin 24-48 hours (range of 12-72 hours) after exposure and last 24-48 hours. The illness can last 72-84 hours in the elderly or in those with weakened immune systems. Most cases have no, or slight, fever.

### ***Recommendations***

In general, viral gastroenteritis can be prevented by strictly adhering to the following guidelines:

- Practice good hygiene:
  - Thoroughly wash hands with soap and water after using the restroom; after changing diapers; after assisting someone with diarrhea and/or vomiting; after swimming; and before, during, and after food preparation (please refer to [Quick Facts about Hand Washing](#)).

- Clean food preparation work surfaces, equipment, and utensils with soap and water before, during, and after food preparation.
- Eat safe foods and drink safe water (Remember: Contaminated foods may look and smell normal):
  - Wash all produce before eating raw or cooking.
  - Use treated water for washing, cooking, and drinking.
- Protect others:
  - Persons with diarrhea and/or vomiting should not prepare food or provide health care for others and should limit direct contact with others as much as possible.
  - Persons with diarrhea and/or vomiting should not attend a child-care facility or school.
  - Persons with diarrhea and/or vomiting shall be excluded from employment involving food handling (Indiana Retail Food Establishment Sanitation Requirements, 410 IAC 7-24-122).
  - Do not change diapers near recreational water.
  - Do not go swimming or use hot tubs if you have diarrhea and for at least two weeks after diarrhea stops.

#### Recommendations for Correctional Facilities

- Disinfect all common surfaces, including but not limited to countertops, chairs, desks, restrooms, floors, handrails, elevator buttons, phones, and computer keys, with a 10 percent solution of household bleach.
- Ensure all restrooms are fully supplied with soap, disposable towels and/or functioning hand dryers. Common towels should not be used.
- Stress the importance of hand washing to all inmates and staff within the facility.
- Isolate all inmates and exclude staff members who become ill.
- Cease transportation of prisoners through the facility until the outbreak is over.
- Limit the transfer of prisoners and staff from the affected buildings.
- Instruct inmates and staff to implement hand-washing techniques when entering building units.

The Indiana State Department of Health extends its appreciation for the outstanding professionalism demonstrated by the Vigo County Health Department and the Federal Correction Complex staff during this investigation.



# ***Registration Information Coming Soon!***

## Indiana Immunization Conference October 2008

October 6: Holiday Inn Lakeview  
Clarksville

October 8: Indiana Government Center South  
Indianapolis

October 9: Hilton Garden Inn  
South Bend

**Register soon at**  
**[www.in.gov/isdh/17094.htm](http://www.in.gov/isdh/17094.htm)**

**Questions? Call 800-701-0704**



**3 Dates!**

**3 Locations!**





## Public Health Cafes

Join us for our monthly Public Health Cafes! Similar to 'Grand Rounds,' these sessions offer public health professionals an opportunity to network with other professionals, learn about relevant resources, and gain insight from local experts on a variety of topics.

**Time:** 8:00-9:30 am  
**Location:** IN MAPHTC Training Center  
 714 N. Senate Ave., Room 220, Indianapolis  
 (Free parking is available next to the building)  
**Fee:** Free  
**Includes:** Continental breakfast and materials



Unable to join us in person? All Public Health Cafes will now be available by live webstreaming! Simply indicate on the registration form that you will be viewing online. You will receive specific log in and viewing instructions in your confirmation email.

**Basic system requirements:** All users need Adobe Flash Player 8 or 9; broadband connection; and cookies enabled in your web browser. **Windows users:** Windows XP Professional or Home Edition with Service Pack 2 or Windows Vista. **Macintosh users:** Mac OS X v10.4; Safari 2.0; Mozilla Firefox 1.5.03.

Date	Topic	Description
Sept. 16	Person/Patient Centered Care	Person/Patient centered care is a relatively new phrase and philosophy being used in clinical care. The speakers will cover the basics of person centered care and discuss ways to use it to better care and communicate with individuals.
Oct. 21	Animal Health	This session will provide an update on animal health issues that public health professionals need to be aware. Two veterinarians will answer your questions and provide guidance and resources.
Nov. 11	Children and Environmental Health	Environmental health concerns have a special impact on children. The speaker will discuss pressing issues that need to be address in order to improve children's health.
Dec. 16	Chronic Disease Management	As more and more of the population deals with chronic disease, learning how to address on-going issues becomes vital. Learn about some of the most common chronic conditions and considerations that maybe needed from a public health perspective.
Jan. 13	Behavior Change	This session will explore techniques to help others change negative health behaviors into positive actions. The speaker will offer theory, tips, and suggestions on incorporating behavior change models into daily work.

## Emergency Preparedness Month Workshop: Creating Partnerships in Emergency Preparedness and Emergency Management

**Date:** September 22  
**Time:** 1:00-5:00 pm  
**Location:** IN MAPHTC Training Center  
 714 N. Senate Ave., Room 220, Indianapolis  
 (Free parking is available next to the building)  
**Fee:** \$25  
**Includes:** Break service, certificate, and materials

**National  
 Preparedness  
 Month**

To celebrate Emergency Preparedness Month, the Indiana Department of Homeland Security and Indiana Mid-America Public Health Training Center will be co-hosting a half-day workshop on creating successful partnerships in emergency management and emergency preparedness.

### Agenda

Registration	12:30-1:00 pm
Welcome and Introductions	1:00-1:15 pm
Session 1: Overview <i>This session will offer brief overview of concepts, language, and guidelines in management and preparedness.</i>	1:15-2:15 pm
Break	2:15-2:30 pm
Session 2: Lessons from the Floods <i>This session will demonstrate the successes and challenges of preparedness and management during the recent Indiana floods.</i>	2:30-3:30 pm
Break	3:30-3:45 pm
Session 3: Promising Practices <i>This session will highlight an Indiana county that has created a strong partnership between preparedness and management systems.</i>	3:45-4:45 pm
Summary and Evaluation	4:45-5:00 pm

## A Toolkit for Managers:

# The *CSI* Approach to Strategic and Business Planning



**Date:** October 16  
**Time:** 9:00 am-3:00 pm  
**Location:** IN MAPHTC Training Center  
 714 N. Senate Ave., Room 220, Indianapolis  
 (Free parking is available next to the building)  
**Fee:** \$40  
**Includes:** Break service, lunch, materials, and certificate

Just as the popular television show series “*CSI*” has sparked an interest in the science of forensics, attending this workshop on strategic and business planning can provide the DNA and investigative tools one needs to implement a successful strategic and business planning process.

Every organization, from the smallest to the largest, needs to make decisions about what it can or cannot do, where it wants to go (the future), and how it’s going to get there. Healthcare and public health organizations in particular, are experiencing increased competition for attention (by the media or policy makers), funds and other needed resources, such as volunteers. Having the most effective strategic approach to setting organizational priorities, therefore, will bring success. This success, in turn, means the organization will enhance the lives of the people we serve and make an even bigger impact on how society views public health and social services.

Steve Notaro, Ph.D., MAPA, CAWA and Nancy McKenney, MNPL, CAWA saw a need to develop this workshop. “In my career in healthcare and not-for-profits, I have witnessed that organizations that plan strategically for their future are more successful, raise more funds, and are more able to adapt to a changing environment”, states Notaro. The question then arises; why don’t more organizations put more effort into planning? Notaro has found the answer may be very simple, “It appears that most professionals simply are not sure how to plan for the now and for the future.”

This planning seminar provides attendees the key tools to revitalize their agency’s planning efforts. “A key ingredient to successful planning is that the leaders of organizations must have a clear vision of the future of the future and a real passion for getting there. But how does a leader create a shared vision of the future that the board, staff, volunteers, and supporters all endorse? How does a leader prepare an organization for the planning process? And how does a leader use a strategic plan to move an organization to new heights in the face of a chaotic and changing environment? When there is disagreement on these questions many organizations simply give up on their planning efforts. However, this is the time when organizations most need to plan. An executive or board chair, with the right knowledge can move beyond these problems,” Notaro explains.

This session includes the basics of how to write good goals and objective statements and discuss the higher level steps to incorporating the plan and strategic thinking into the organization. Worksheets will provide attendees the opportunity to learn how to draft these statements and serve as a guide to take back to their organizations.

## The Basics of Grant Writing

**Date:** December 2  
**Time:** 9:00 am-Noon  
**Location:** IN MAPHTC Training Center  
 714 N. Senate Ave., Room 220, Indianapolis  
 (Free parking is available next to the building)  
**Fee:** \$20  
**Includes:** Break service, materials, and certificate



Join us for this introductory course on grant writing, designed for those who have never written a grant, have ‘dabbled’ in it, or want to strengthen their basic skills. Alicia Gahimer, from the IUPUI Office of Research and Sponsored Programs, will take participants through topics such as:

- Identifying potential funders
- Exploring and understanding guidelines
- Deciphering the application process
- Completing the application/proposal
- Evaluating and reviewing proposals

## ***How to Register for MAPHTC Programs***

To register for the programs listed in this catalog, simply visit MAPHTC’s website, [www.publichealthconnect.org](http://www.publichealthconnect.org) and click on “Live Programs.” Find the program you’d like to attend in the calendar and follow the registration steps. Please note that we do not accept online payments. For courses with a fee, you will need to send payment to: IN MAPHTC, 714 N. Senate Ave., Suite 250, Indianapolis, IN, 46202.

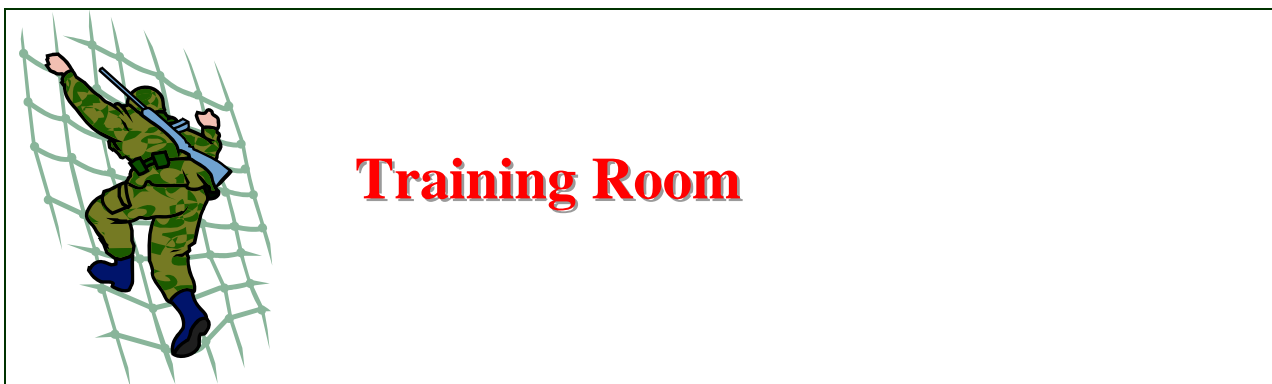
IN MAPHTC courses are designed for individuals working or with interest in public health: government agencies, non-profit organizations, clinical health care, consultanting firms, and academia. Course content and topics are selected based on regular survey of the public health workforce, participant feedback, regional and national research, and the Core Competencies from the Council on Linkages Between Academia and Public Health Practice.

**Full refunds** will be granted to requests received in writing by mail or fax to IN MAPHTC at least 14 days prior to the program for which you are registered. Please allow four to six weeks for processing. Refunds will not be given for no-shows; however, a substitute participant will be accepted.

You will receive a **confirmation** email one week prior to the course that will include any special arrangements or information you may need.

For questions on courses or registrations, please contact Kate Nicholson at [katlnich@iupui.edu](mailto:katlnich@iupui.edu) or 317.274.3178.





## INDIANA STATE DEPARTMENT OF HEALTH IMMUNIZATION PROGRAM PRESENTS:

### *Immunizations from A to Z*

Immunization Health Educators offer this FREE, one-day educational course that includes:

- Principles of Vaccination
- Childhood and Adolescent Vaccine-Preventable Diseases
- Adult Immunizations
  - Pandemic Influenza
- General Recommendations on Immunization
  - Timing and Spacing
  - Indiana Immunization Requirements
  - Administration Recommendations
  - Contraindications and Precautions to Vaccination
- Safe and Effective Vaccine Administration
- Vaccine Storage and Handling
- Vaccine Misconceptions
- Reliable Resources

This course is designed for all immunization providers and staff. Training manual, materials, and certificate of attendance are provided to all attendees. Please see the Training Calendar for presentations throughout Indiana. Registration is required. To attend, schedule/host a course in your area or for more information, please reference

<http://www.IN.gov/isdh/programs/immunization.htm>.

## ISDH Data Reports Available

**The following data reports and the *Indiana Epidemiology Newsletter* are available on the ISDH Web Page:**

<http://www.IN.gov/isdh/>

HIV/STD Quarterly Reports (1998-June 2006)	Indiana Mortality Report (1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006)
Indiana Cancer Incidence Report (1990, 1995, 1996, 1997, 1998)	Indiana Infant Mortality Report (1999, 2002, 1990-2003)
Indiana Cancer Mortality Report (1990-1994, 1992-1996)	Indiana Natality Report (1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006)
Combined Cancer Mortality and Incidence in Indiana Report (1999, 2000, 2001, 2002, 2003, 2004)	Indiana Induced Termination of Pregnancy Report (1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005)
Indiana Health Behavior Risk Factors (1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006)	Indiana Marriage Report (1995, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004)
Indiana Health Behavior Risk Factors (BRFSS) Newsletter (9/2003, 10/2003, 6/2004, 9/2004, 4/2005, 7/2005, 12/2005, 1/2006, 8/2006, 10/2006, 5/2007, 12/2007, 4/2008, 7/2008)	Indiana Infectious Disease Report (1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005)
Indiana Hospital Consumer Guide (1996)	Indiana Maternal & Child Health Outcomes & Performance Measures (1990-1999, 1991-2000, 1992-2001, 1993-2002, 1994-2003, 1995-2004, 1996-2005)
Public Hospital Discharge Data (1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006)	Assessment of Statewide Health Needs – 2007

### **HIV Disease Summary**

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**Information as of August 31, 2008 (based on 2000 population of 6,080,485)**

#### ***HIV - without AIDS to date:***

345	New HIV cases from September 2007 thru August 31, 2008	12-month incidence	6.00 cases/100,000
3,978	Total HIV-positive, alive and without AIDS on August 31, 2008	Point prevalence	69.16 cases/100,000

#### ***AIDS cases to date:***

402	New AIDS cases from September 2007 thru August 31, 2008	12-month incidence	6.99 cases/100,000
4,135	Total AIDS cases, alive on August 31, 2008	Point prevalence	71.89 cases/100,000
8,742	Total AIDS cases, cumulative (alive and dead) on August 31, 2008		

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## REPORTED CASES

 of selected notifiable diseases

Disease	Cases Reported in August MMWR Weeks 31-35		Cumulative Cases Reported January – August MMWR Weeks 1-35	
	2007	2008	2007	2008
Aseptic Meningitis	34	32	137	139
Campylobacteriosis	63	86	307	431
Chlamydia	2,131	1,850	14,092	13,500
Cryptococcus	1	1	14	15
Cryptosporidiosis	21	29	50	124
<i>E. coli</i> , shiga toxin-producing	21	18	51	58
<i>Haemophilus influenzae</i> , invasive	11	4	43	56
Hemolytic Uremic Syndrome (HUS)	0	0	0	1
Hepatitis A	8	1	12	14
Hepatitis B	3	0	29	23q
Histoplasmosis	5	4	62	50
Influenza Deaths (all ages)	Not Reportable	0	Not Reportable	15
Gonorrhea	960	737	5,971	5,452
Legionellosis	8	5	33	34
Listeriosis	3	2	10	5
Lyme Disease	23	8	40	25
Measles	0	0	0	0
Meningococcal, invasive	3	5	18	22
Mumps	0	0	1	0
Pertussis	7	7	47	35
Rocky Mountain Spotted Fever	1	3	5	5
Salmonellosis	129	77	455	399
Shigellosis	35	45	72	493



## REPORTED CASES of selected notifiable diseases (cont.)

Disease	Cases Reported in August MMWR Weeks 31-35		Cumulative Cases Reported January – August MMWR Weeks 1-35	
	2007	2008	2007	2008
Group A Streptococcus, invasive	7	6	90	105
Group B Streptococcus, Newborn	1	2	19	17
Group B, Streptococcus, invasive	31	30	164	202
<i>Streptococcus pneumoniae</i> (invasive, all ages)	18	25	388	592
<i>Streptococcus pneumoniae</i> (invasive, drug resistant)	5	3	117	160
<i>Streptococcus pneumoniae</i> (invasive, <5 years of age)	4	4	30	45
Syphilis (Primary and Secondary)	10	12	34	90
Tuberculosis	15	17	90	90
Yersiniosis	3	0	13	5
Animal Rabies	3 (bats)	1 (bat)	9 (bats)	4 (bats)

**For information on reporting of communicable diseases in Indiana, call the *Surveillance and Investigation Division* at 317.233.7125.**



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